Quality Supports for Family, Friend and Neighbor Childcare Providers

2019 PILOT PROJECT

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ILLINOIS ACTION FOR CHILDREN

Introduction

Illinois Action for Children (IAFC) obtained government funding in 2019 to develop quality supports for family, friend and neighbor (FFN) childcare providers throughout the state. The purpose of this pilot was to ensure the FFN providers were equipped with tools and resources they need to provide the best quality care for children and prepare them and their parents for school readiness. IAFC worked with providers in Cook County and three other communities throughout the state (Moline, Peoria, Cairo).

The project was divided into four phases of implementation:

I. **Focus groups** – IAFC held six focus groups across the state with a total of 50 providers participating, answering pre-determined questions developed in conjunction with our research team.
II. **Professional Development creation and delivery** – IAFC developed training content areas based on the responses from the focus groups and in consideration of what was anticipated that we listed in the grant application. In partnership with community partners and Child Care Resource and Referral agencies (CCR&Rs), we offered the specified training to providers to enhance their knowledge base.
III. **Site visits** – FFN providers that participated in professional development also had the opportunity to receive a site visit to build deeper relationships with local childcare resource agency and get one-on-one support.
IV. **Evaluation** – Each phase of the process was evaluated including surveys and follow up calls to determine if the process and supports were beneficial to providers and their overall professional growth in supporting children.

This report will go in depth in each phase of the process, providing the reader with insight into a variety of communities across the state and the challenges and benefits that this pilot project uncovered.

Phase I: Focus Groups

IAFC hosted six focus groups; three in Cook County and three across the state in conjunction with CCR&Rs Service Delivery Areas (SDAs) 7, 8 and 16. The CCR&R agencies we partnered with are SAL Family and Community Services (SDA 7), SAL Child Care Connection (SDA 8) and John A. Logan College (SDA 16). The specific communities that were served in these areas are Cairo, IL (Alexander County), Moline, IL (Rock Island County) and Peoria, IL (Peoria County). Additionally, we partnered with three of our community partners in the Chicagoland area; Carole Robertson Center for Learning (to serve the Spanish speaking population), Centers for New Horizon and Good Shepherd Center (all serving Cook County).

We identified childcare providers serving the state's identified priority populations to engage in this pilot initiative. Some of those characteristics included families that were at-risk or underserved based on their socioeconomic status, the community in which they reside or the lack of resources available to them in their immediate area. Some of these populations may have been impacted by homelessness, teen pregnancy, trauma, children with disabilities, children that face barriers due to immigration status and other challenges that may be present.

Providers were targeted through the Child Care Assistance Program (CCAP) with the above-mentioned factors in mind. We aimed to have 10-12 participants for each focus group. We impressed upon our partners to solicit providers that would be open-minded and have minimal hesitation in sharing their concerns.

IAFC marketing team developed a flier with details of the focus group for each gathering. The fliers were specific to the area and community to be served and listed all logistical information. Each partner mailed out fliers electronically and/or through traditional mail to the providers to garner their interest. Sites were instructed to over enroll by about five people to account for participants that would inevitably drop off.

The following table highlights confirmed participants versus actual numbers of providers that attended:

Table 1: Focus Group Participants

Site Name	Confirmed Participants	Actual Participants
Centers for New Horizons	14	7
Carole Robertson Center for Learning	9	9
Good Shepherd Center	24	9
John A. Logan College	12	11
SAL Child Care Connection	10	8
SAL Family and Community Services	12	6

**Some of the actual participants had not confirmed their attendance but showed up because they had received the information.*

As an incentive for participation, each provider received a $50 gift card for their time. Participants were extremely grateful for the incentive and was sure to talk of how it motivated them to attend the session.

Unique community: The John A. Logan College CCR&R selected one of the most, hard-to-reach communities in southern IL; Cairo, in Alexander County. The community suffers from rural isolation and does not have the basic necessity of a local grocery store in their immediate vicinity. Coming together in the cafeteria of the local junior and high school combination building, we learned that this specific community lacks many of the resources we take for granted, such as quality food, a community center to provide additional resources, medical center or nearby hospital. Following is a more in-depth look into Cairo, IL; displaying a community that may be identified as one of the hardest to reach in effort to provide resources to care-takers and families as a whole.

A full detailed focus group evaluation report is included.

Facilitator Observations (LaTrice Davis):
In this section, I will highlight some of the observations I witnessed during the focus group sessions that relate directly to the communities where the focus groups were held. The first group was held in Alexander County, at the southern-most part of the state in Cairo, IL. The community is desolate, and void of the resources taken for granted in other parts of Illinois. The meeting was held at a local school, junior/high school combo building, sitting non-descript, back from the main road. The streets leading to the school were quiet with minimal activity. I wondered if I was in the right place as I followed the GPS directions to the parking lot.

Once inside, the school was well-maintained and the halls were lined with trophy cases, highlighting the accomplishments and accolades of students, primarily athletes. It was the summer, so students were on break and the school was open only for the focus group to be conducted.

As the participants started to arrive, they were a lively bunch. Some knew each other from different settings and others were meeting for the first time. This group of providers were all women and they were very friendly and eager to share their thoughts and opinions on the questions that I asked. While the evaluation report details the more specifics of the groups, I want to point out what I consistently heard over and over again as it relates to this group specifically. One of the questions I was prepared to ask had to do with the available community resources to support providers toward caring for children. I took note of what was previously being said and what I had witnessed on my drive in to shift the question to ask how they locate, and access resources given most of their needs are not in their immediate area.

The all-female group kind of chuckled and someone said, *"We don't. There is nothing here."* I looked around the room and could tell this was the sentiment of just about all of the women. They then went on to speak about the closest grocery store being about 20-25 mins away and made mention that it could be longer if a certain bridge (that was the connecting point to another community) was out which was their shortest route. Otherwise, they'd have to take a longer route; going around the river. The providers spoke of older kids not having productive things to do other than go to the park and that was sometimes out of the question if trouble was lurking at the park or it was too cold. They continued to emphasize there was absolutely nothing to do and often, they could not quickly get the things they wanted or needed.

It was a harsh reality that took me by surprise, living in a city that afforded me every opportunity to get to a grocery store in less than five minutes; to call the local park district or Boys & Girls Club to find out about their upcoming programs for my school-age daughter. I kept thinking and asking myself how many other communities are similar to Cairo across this state, across the country. In keeping with the focus of this project, it was difficult for me to see how our perceived offerings would benefit this group of providers who could not get some of their basic needs met. Additionally, some of these providers did not have access to consistent transportation and there is no public transit system. Many of them were in a constant state of trying to figure out how they would get to and from the places they needed. And, even though they lacked some of the basic necessities of larger communities, many of the providers

were not eagerly interested in training that could be provided online. Some of them were open to it and others dismissed it touting the availability of a computer, the internet or the simple know-how.

The focus group in Cairo left me shocked and uncertain how we could benefit communities that had so little. Before I headed 45 minutes north to another town that I would be staying for the night, I drove further west into Cairo, noting only a Dollar General and a gas station that actually looked open. There were some buildings that looked like they once held businesses that were no longer in operation. The streets were eerily empty, and buildings dilapidated. It definitely did not look or feel like an operable town. After a two-or-so-mile stretch, I turned around heading back toward the highway, feeling disappointed and helpless.

My other visits to Moline, IL, Peoria, IL, and areas surrounding Chicago, did not prove to be as challenging. The above-mentioned communities all had available resources that could support the providers in their journey of offering childcare to family, friends and neighbors. For many of these other areas, the resource agency was embedded in the community and was fairly easy for providers to get to and connect with for other opportunities offered throughout their immediate location.

The common theme that I recognized in the focus groups was the desire to be a part of consistent groups like the one we created with the focus group. It was clear that many of the providers shared some of the same concerns and/or need to talk through some of the things they had experienced. For example, in many of the groups, providers shared a resource or two that others had no idea existed. In one group, one of the providers informed the group that she uses the food program to offset costs. Most of the other providers in the room had no prior knowledge of the food program and they were grateful for someone sharing so they could get more detailed information. Additionally, there was a provider that talked about an online resource she uses to teach the children in her care to help them learn their alphabet. Providers quickly picked up their pens to write down the name of the resource. It was this openness and willingness to share that reminded me of the need for social capital for this group of providers that may often feel isolated.

Overall, the focus groups were enlightening and provided us a direct line of sight into the challenges that family, friend and neighbor providers face. For most, they are seeking more ways to connect with other providers, have challenges attending professional development if childcare is not included and many lacks either the resources or the skills to rely on web-based opportunities. We took what they shared and developed training opportunities that would begin to meet their immediate needs.

Phase II: Professional Development creation and delivery

The focus groups provided our team the opportunity to learn what providers were missing as they thought about caring for children. In our grant application, we also anticipated the needs of providers, listing topics such as understanding child behavior, teaching through play, brain development, nutrition, social emotional learning and school readiness to name a few. Because we have the history of working with providers, we were confident in identifying areas of growth. The focus groups helped us to see that we were aligned to what was verbalized.

We created a crosswalk that compared topics listed in the grant against what was shared in the focus group to what IAFC already offered. While we know that our partners did not necessarily offer the exact type of workshops, we figured they would have some similarities. After this comparison was complete, we realized that we did not necessarily need to create a full curriculum but instead we could pull from what we already offered. In keeping true to what we said in the grant application, we chose to offer eight hours of professional development for family, friend and neighbor providers. It was important to us to focus on the topics shared by the providers. We wanted to display to them that we heard their needs and would support them by giving them what they were asking for. After evaluating our crosswalk, we decided on the following training topics:

Table 2: Professional Development Topics

	Training Topic	Description
Week 1	Child Development (2 hours)	The growth and development of a child including physical growth, cognitive and social development.
Week 2	Social Emotional Learning (SEL) (1 hour) Trauma (1 hour)	Helping children to understand and manage emotions in the child-care setting and home. The focus will also be on tools and resources needed to support children through trauma experienced in their lives.
Week 3	Children and technology (1 hour) Relationship building with parents (1 hour)	The first half of this training will be to support providers in managing the use of technology to help children learn and not as a form of babysitting. The second half of this training will focus on helping providers build quality relationships with parents so they can work together for the best interest of the child.
Week 4	Literacy (1 hour) School readiness (1 hour)	Helping providers teach children the basics of reading and writing in preparation for school. This session will ensure that providers have a checklist of what children will need to know for Pre-K and Kindergarten.

We believed these seven topic areas were a good starting point, especially for those providers that had minimal or no previous professional development opportunities. The primary goal was to offer sessions that taught the basic principles of the growth and development of a child. And, because our priority populations were mostly individuals who may have experienced or observed traumatic events, we wanted providers to have an understanding of how to navigate those challenges. At the end of these sessions, we wanted to have providers that were equipped with more knowledge and an increased skill set in how they worked with and on behalf of children and the focus of preparing them for school.

For each training topic, an outline was developed as a guiding post to make sure that at least those specific points were incorporated into the sessions.

The outlines for each session are attached as Appendix B.

The facilitators for the sessions were a mix of hired trainers (in Cook County) and staff (Moline and Peoria). In the Cook County area, we often use these facilitators for training that is provided throughout

the year and some of them had previously trained on the topics we were offering. In both Moline and Peoria, they saw this as an opportunity to expand the capacity of their staff by having them use the outlines and do some additional research to conduct the trainings.

The trainings that took place in Moline, Peoria and at Centers for New Horizon were offered for a full, one-day option. These sites spent eight hours on a Saturday giving providers the tools they needed to enhance their childcare. Good Shepherd Center offered their training over a two-day period and Carole Robertson for Learning offered their training over a series of four sessions; three completed prior to the end of this pilot grant period with the final session being held during the first week of February 2020. Providers will receive professional development credit for their participation in these trainings through the IL gateways system.

Overall, we had 62 providers that participated in professional development sessions throughout December and January. All of the sites self-reported that the topics were well-received, and the participants seemed to get a lot out of going through the training with other providers that were in similar circumstances. It seems that they drew on the challenges of each other; grateful that they were not "in it alone." This then is a sign that there is a great benefit to the social capital that is created by putting providers in the same room as their peers and encouraging conversation and even collaboration as they think through what is happening with the children they care for. This might be one of the greatest benefits that is often difficult to quantify. As we think about future investments in this population, it may be advantageous to create informal networks (the provider circle) that gives providers the opportunity to simply talk about what's going on and what they need help with in being a family, friend or neighbor home-based provider.

The challenges we experienced with offering the training were centered on timing; time of year (holiday season), childcare and the quick turnaround of the pilot project in general. Partners expressed the constant battle they faced in getting license-exempt providers to commit and attend trainings. Some providers have expressed they provide care on the weekends or evenings in addition to during a traditional day. Other providers are not as invested in obtaining professional development because they may only be providing care for the short-term or they don't see the benefit of participating in the sessions in general. Some of this may have to do with the narrative that providers are often seen simply as babysitters and not as one of the child's first teachers. It is our responsibility to continue to support their growth and development and change their mindset about their services.

As mentioned earlier, Cairo, IL was presented with a different set of circumstances as they battled minimal resources throughout their community. Our CCR&R partner immediately recognized the unique deficit and outcry for this group to give them what they actually needed and not what we thought was best for them. The first training they offered centered around the child and adult food program. As stated, there isn't a grocery store in Cairo and the Dollar General does not sell 1% milk; the milk providers must serve to children when they are on the food program. The group brainstormed some solutions that would support their participation in the program because several of the providers were interested. Unfortunately, the presenter did not spend enough time supporting providers in the way they needed and quickly shifted into the administrative requirements of the food program. While this may have been a warranted diversion for a different provider group, it was not the ideal change for this group as they were still trying to fully embrace solutions they would need to overcome to have any involvement in the food program in general.

The other training sessions offered to the providers in Cairo were:

- Choosing developmentally appropriate toys/activities
- Preparing for taxes
- Focusing on literacy and books

The session about taxes was another specific request from providers as those offering support for the first time expressed a need to understand the nuances of filing taxes for their greatest benefit. While we recognize the importance of financial management and even budgeting in operating what some view as a small business, our providers don't always get the specific development they need, and we sought to change that with this pilot.

Phase III: Site Visits

Just as important as offering training sessions to providers was our ability to connect with them on an individual basis and answer any in-depth questions, they may have had pertaining to resources or needs. Our team conducted site visits to their home to share local resources with them, as well as offer any hands-on assistance in teaching a new activity to a young child or providing more information about the food program. No matter their need, we worked with them to solve the problem or pointed them in the direction where they could get additional support. Of the 62 number of providers that participated in professional development, about 50% also received a home visit.

According to our team lead that led the home visit process, it was seen as a beneficial time to enhance deeper connections between our licensed-exempt monitors and the providers. This helps to break down or alleviate barriers altogether and for future involvement. These visits also uncovered providers having an interest in becoming a licensed home provider, which can lead them toward a long-term career in early childhood. While the purpose of our visits was to primarily serve as a resource, it is inspiring to hear that some of the providers are interested in digging deeper into the work by supporting families in a more intentional way.

While some providers may have been equipped with tools for the children they serve, it was our pleasure to provide them with information about local resources, such as the libraries that often have daytime programs for young children. Some of this programming includes story hours, arts and craft activities or performances that are often free and open to the public. The above-mentioned activities allow providers to expose the children in their care to something greater while keeping expenses low. In addition, providers received an overflow of resources specific to the age of the children in their care. The home visits were tailored in a way that focused and served each provider individually. It was important for our team to answer provider's specific questions and help them navigate any challenges they may have been experiencing to that point.

The evaluation report will discuss the feedback that providers had about the home visits. Please see the attached report for more detailed information.

While the success of many of our home visits shows many providers welcomed us into their home; there is a flip side. Some providers were not as eager to participate in a site visit, even if it meant meeting at a local community space. When asked about their hesitation, providers have simply been dismissive and not interested in answering that question. In speaking to one of the managers in the license-exempt monitoring department, he made mention that some providers don't feel comfortable due the possibility of a compliance issue. It was also discussed that as a cultural norm, some providers at the base level are not comfortable with strangers coming into their home. We recognize that all people are not proud of where they live or may feel embarrassed by what they don't have. There are many speculations about why it can be a struggle to get providers to participate in a home visit. It is often difficult if they have never met the person and don't understand the need for the visit. These barriers have to continue to be broken. Our theory is that if providers continue to engage with us during informal opportunities, they will become more comfortable and eventually welcome us for a 15-20-minute visit to provide them with resources they may need.

Phase IV. Evaluation

Evaluation methods have been incorporated throughout the Quality Supports pilot project. We surveyed all participants of the focus group. Team members were asked questions about the process of developing the training sessions and why specific topic areas were selected. A sample of providers that participated in professional development were surveyed about their experience and the benefit or lack thereof. And, we also surveyed a sample of providers that received home visits. These surveys and follow up conversations will inform how we move forward in interacting with family, friend and neighbor providers in the future. It's important for us to decipher what worked well for them and what changes need to be made. The attached evaluation reports will provide details of survey results and process implementation.

Observed Opportunities:

- FFN providers are seeking social support networks that encourage informal dialogue and connection between others that serve in similar situations. There is an opportunity for CCR&R's to create less structured gatherings (possibly with childcare) that facilitate community and connection.
- Incentives are necessary to engage providers initially, especially in under-resourced communities. Providers are more likely to attend events (formal and informal) if it is specifically stated what they will receive from being involved.
- Start where the providers are. As we saw in Cairo, IL a community in need means we should offer solutions that support their immediate growth and not what we think is best. Cairo was a lesson in listening and acting based on the request of the group.
- Relationships are key. In order for providers to feel more connected to CCR&R and other partners, time must be invested to build solid relationships. A provider is more likely to engage when they have a personal, intentional connection with an individual they can call upon to ask questions.

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Family, Friend and Neighbor Quality Supports

Child Development

I. What is child development? Why is it important?
   a. The process of learning and mastering skills such as sitting, walking, talking. Based on a child's age, there are developmental milestones they are expected to reach

II. Five areas of development:
   a. Cognitive development: learning and solving problems
   b. Social and emotional development: ability to interact with others, understanding how to be independent and exercising self-control
   c. Speech and language development: understanding and using language
   d. Fine motor skill development: the ability to use small muscles like hands and fingers to pick up crayons to draw, turn pages and hold a utensil
   e. Gross motor skill development: the ability to use large muscles

III. Putting child development into practice:
   a. Play – children 0-5 primarily develop through play; exploring, observing, experimenting, solving problems and learning from mistakes
   b. Healthy eating – learn about food choices, provides children a sense of taste and the proper nutrition gives children energy and the nutrients and vitamins they need to grow and develop
   c. Physical activity – gets children moving (both inside and outside) to develop their motor skills
   d. Health – observing the child's overall health is important to their growth and development (pay attention to warning signs that there may be a greater issue)
   e. Neighborhood and local community – positive development is supported by loving relationships and local community resources (think "it takes a village")

IV. Understanding developmental delays
   a. Don't forget all kids develop at different rates
   b. Consider if the child is continually behind in gaining skills for their age group
   c. Why do development delays occur?
      i. Complications at birth
      ii. Environmental issues
      iii. Other medical conditions

V. Best Practices
   a. Constantly use language to talk to and engage with a child
   b. Play with children, not just encouraging them to play
   c. Read a variety of books and other materials

Family, Friend and Neighbor Quality Supports

Social Emotional Learning (SEL)

I. What is SEL? Why is it important?
   a. Helping children to understand and manage their emotions, feel and show empathy for others, establish healthy relationships, set positive goals, and make responsible decisions

II. Fostering positive SEL
   a. Provide responsive care – understanding likes and dislikes and their interest in mimicking what you are doing
   b. Explore with them – get on their level to see the world as they do and interact with them by showing them and explaining to them what you see
   c. Be affectionate and nurturing – touch, hold, comfort, sing, rock, talk to
   d. Provide them safety and security – responding to their cries and other communication
   e. Understand the child's home culture – are there things that happen at home that you can incorporate into your child care
   f. Strong, positive relationships

III. SEL skills needed for school
   a. Confidence
   b. Developing good relationships with peers and adults
   c. Communicate emotions
   d. Listen to instruction
   e. Problem solving
   f. Ability to concentrate

IV. Best Practices
   a. Model behavior you want child to learn
   b. Use a variety of strategies to engage children

Family, Friend and Neighbor Quality Supports

Trauma

I. What is Trauma? Why is it important to caring for children?
   a. When a child feels threatened by an event that he or she has been involved in or witnessed
   b. Traumatic events typically cause reactions that are on-going as they process and deal with what has occurred.

II. Types of Trauma (this can be an activity for participants to list out types)
   a. Sudden departure/loss of a parent or close family member
   b. Community violence
   c. Sexual abuse
   d. Homelessness

III. What a child might display after trauma
   a. Having intrusive thoughts about the trauma, whether it be an event or series of events
   b. Having dreams or nightmares that involve the trauma
   c. The feeling that the trauma is occurring again
   d. Distress at reminders of the events
   e. Mood changes/shifts
   f. Inability to concentrate or focus
   g. Fear danger is always near

IV. Best Practices in helping a child and/or family through trauma
   a. Remain calm
   b. Meet children where they are – if they have the language to express what they are feeling great, if not, allow them to explain in their own way, maybe encourage them to draw
   c. Assure them it is not their fault – if a child's action led to a traumatic event such as placing something on the stove that causes a fire, seek professional assistance to help them understand cause and effect without placing blame
   d. Encourage them to grieve in their own way, reminding them there is no right or wrong way
   e. Encourage them to ask questions have open dialogue about what took place

**(adapted from Center for Child Trauma Assessment Services and Interventions at Northwestern University)*

Family, Friend and Neighbor Quality Supports

Children and Technology

I. What is Technology?
   a. Commonly referred to as screen time in which children are using mobile smart phones, tablets and television

II. Media use: (some findings based on research conducted by Common Sense Media specifically for this age group)
   a. Children under the age of two spend an average of 58 minutes per day with screen media. Forty-four minutes of that time is spent watching television.
   b. Children aged two to four spend an average of one hour and 58 minutes per day with screen media. One hour and four minutes of that time is spent watching television.
   c. Sixteen percent of children under the age of two, and 37 percent of children aged two to four have a television in their bedroom.
   d. Forty percent of children aged birth to one year, and 76 percent of children aged two to four years watch "educational shows," described as "Sesame Street," "Mythbusters," and the like.
   e. Devices for playing games are the most commonly used types of mobile media (63 percent).
   f. Parents of children aged birth to eight say they use media to occupy their children when they are running errands together (23 percent, often; 80 percent, sometimes) and doing chores at home (13 percent, often; 42 percent, sometimes). (Rideout, 2013)

III. The good with screen time?
   a. There are a variety of educational apps that promote learning (or are there?)
   b. It teaches independence in which children are able to learn on their own (is this necessary)

IV. The concerns with screen time?
   a. There is less transfer of learning (children are not always able to mimic or implement what they see on the tablet)
   b. Children learn through engaging their mind and body
   c. It's a passive way to learn
   d. Excessive screen use aids to obesity, sleep problems, and difficulties in school

V. Best Practices in using screen time
   a. Consider the child – how do they learn? Are you joining them in the learning process while they use the tablet?
   b. What is the content – what is the information the child is learning? How is it transferred or applied to real life?
   c. What is the context – is a set time that the child is engaging in screen time and for how long?

Family, Friend and Neighbor Quality Supports

Relationship building with parents

I. What is relationship building?
   a. The ability to positively connect and openly communicate with the child's parent/guardian, especially for the benefit of the child

II. What are the challenges with connecting with parents? (have participants list or call out)
   a. Familial relationships – often difficult to tell daughter or niece about what could be done with their child
   b. Strained relationship outside of caring for child
   c. Lack of respect in the relationship
   d. Parents not wanting to be told "what to do"
   e. Being taken advantage of because provider is family

III. Combatting the challenges
   a. Be intentional and consistent with communication
   b. Learn and understand the family – find out what kinds of things they are doing at home
   c. Be knowledgeable, but not a know it all – even if you have parented or taken care of hundreds of children, allow the parent the opportunity to learn from and with you
   d. Listen before offering advice – sometimes parents just want to be heard, but may not want your assistance
   e. Be optimistic and maintain a positive attitude – even when tension is high believe that the parent wants what is best for their child
   f. Share the love – send pictures of what the child is doing throughout the day or share if they have learned new skills

Family, Friend and Neighbor Quality Supports

Literacy in early childhood

I. What is literacy? Why is it important?
   a. The ability to read and write. Every child should learn the basics of reading and writing to help them discover the world around them.

II. Encouraging literacy
   a. Using pictures and objects, letters and words and use sounds
   b. Talk about everything you are doing and encourage their explanation
   c. Share stories to help children learn and encourage them to share in the story
   d. Visit the library
   e. Point to words and look up the meaning of unknown words together
   f. Reflect on reading ask and answer questions about what you read

III. Putting it into practice (use a variety of activities to show how literacy can be developed)

Evaluation Report for Focus Groups with Family, Friend and Neighbor Child Care Providers

Introduction

In 2019 Illinois Action for Children received a grant to develop and pilot ways to assist family, friend and neighbor (FFN) child care providers in Illinois to improve the quality of their care for young children, including supporting the children's school transitions.

As part of the larger project, Illinois Action for Children conducted six focus groups which 50 FFN providers attended. The goal of the focus groups – held in July and August 2019 – was to learn about providers' need for training and other resources, as well as their interest in various ways to receive these supports.

Focus Group Participants and Host Organizations

Recruitment of focus group participants targeted FFN providers who care for children under the program Child Care Assistance Program (CCAP). In Cook County, Good Shepherd Center, Carole Robertson Center for Learning and Centers for New Horizon hosted and recruited FFN providers for focus groups, including one conducted in Spanish. Elsewhere, partnering Child Care Resource and Referral Agencies, John Logan College, SAL Family and Community Services and SAL Child Care Connection recruited FFN providers for three focus groups in Alexander, Rock Island and Peoria counties.

From the 50 participants, 48 completed the pre survey and reported the following demographic characteristics:

	Cook County	Other Counties	Total
Number of participating providers	23	25	48
Age of providers			
Age 39 or under	7	0	7
Age 40 or above	16	24	40
Ethnicity			
Latinx/Hispanic	11	1	12
Race			
African American	13	18	31
White	5	6	11
Other	6	1	7
Ages of Children in Care			
Care for children under 5	29	19	48
Care for school-age	10	20	30
Serving priority populations			
Children with Special Needs	0	2	2

Children of teen parents	3	2	5
Children of immigrant parents	2	0	2
Children who have a refugee or asylum status	1	0	1
Hours of care			
Children in care during nontraditional hours	9	7	16

**Some providers did not answer some demographic questions.*

Participation by Site Partner

Site	Number of Participants
John A Logan College	11
SAL Family and Community Services	6
SAL Child Care Connection	8
Carole Robertson Center for Learning	9 (Spanish focus group)
Centers for New Horizon Effie Ellis	7
Good Shepherd	9

FFN Focus Group Process

The focus groups were facilitated by Illinois Action for Children staff. The three Cook County focus groups were facilitated by the Research and Evaluation Analyst and the other three, by the FFN Project Manager. Providers received a $50-dollar gift card for their participation.

Each focus group was recorded and transcribed for analysis and summary. A confidential pre-focus group survey of participants elicited their demographic information. At the end of the focus group a confidential post-focus group survey was distributed for participants to evaluate the focus group and to make follow-up comments.

Findings of Focus Groups

FFN providers raised a number of points in the focus groups, that are useful for the design of provider trainings and other supports These are summarized here.

Motivation for Providing Care

We first asked FFN providers about their motivations for providing care. “Distrust of others” was the most frequent response. Many FFN providers were grandparents or great grandparents of the children in their care and they or the parent did not trust strangers to care for the children. Providing stability and support for the parent was the second most common theme, as some children seemed to be in a single parent family: “I provide stability to the parents of the children

that we're watching." Another common response was that they had previous experience working with children, such as being a licensed provider at one time, being a foster parent or working in a school. Additional responses included providers wanting to be an influence in the child's life, and parents not having other options because of their nontraditional work schedules.

Supports and Resources in Which Providers Expressed Interest

FFN providers described an array of supports that could help them in their caregiving. Their most common response was that they need more activities to do with the children. Providers wanted more outdoor activities or activities to help children learn. Some providers reported not feeling safe going outside to play, and wanted more activities to do at home.

Access to learning materials was another common need, "Educational books would be wonderful." Help with the cost of food for the children was the third most common theme.[1] A lending library where providers could check out free materials came up during two different focus groups.

In the Spanish focus group, almost half of the participants expressed their desire to become licensed providers and wanted help navigating that process. Two participants in the English focus groups also brought up wanting to become licensed.

Other resources that were mentioned:

- Provider support groups – some providers expressed interest in opportunities for camaraderie with other providers. Within the focus groups themselves, they appeared to appreciate learning about information and resources from each other.
- Child care items such as beds and toys
- Higher CCAP payment – some providers discussed how their CCAP earnings help meet the children's needs such as food but very little was left for their own use or additional activities. They also discussed their long hours and how CCAP payments do not increase as their hours increase (after the 5-hour point).
- Information on programs such as food programs, grants, and resources to help the parent
- Mental health services for children

Learning about resources: When FFN providers were asked what would be the best method to learn about resources, a workshop was the most frequent response. Having handouts and flyers around the community was another method mentioned. Some providers also suggested having social events as a way to learn about resources.

[1] While other types of providers need food assistance, this need is particularly acute for FFN providers. They receive just $16.92 per day from CCAP for a full-time child – between 35 and 48 percent of the reimbursement other providers receive for a full-time child under age 2. See Illinois Department for Human Services: http://www.dhs.state.il.us/page.aspx?item=106228

Other methods:

- Mail information
- Email information
- Outreach in the community
- Text information

Professional development

FFN providers mentioned a number of areas in which they would like to learn or build skills. First, they deal with parents at a more personal level. Therefore, it was not a surprise that all focus groups expressed the frustration of communicating issues with parents or setting boundaries.

Children's development was another area of interest. Providers were interested in learning developmental milestones as well as activities to support children in reaching the milestones. Some providers had specific interest in helping children in their care with delayed speech, autism or sensory disorders.

Behavior was another topic that FFN providers mentioned. Providers' concerns regarding behaviors ranged from understanding children's actions and ways to respond to behavior such as a baby crying and learning how to discipline a child.

Other interests included:

- Trauma Informed Care
- Working with children with special needs
- Children and Technology; finding ways to engage children when children only want to be using technology.
- Nutrition
- Technology Literacy for Providers
- First Aid
- Fire Safety

School Readiness

All focus groups reported that to some extent providers are helping the children in their care to get ready for school by teaching them fundamental skills. Some of the skills include: knowing ABC's, coloring, counting, identifying shapes, reading, writing and math problems. Some providers also reported helping children to be ready for school in non-academic ways by teaching them how to behave socially, potty training and making sure the children have the appropriate school supplies.

Resources: Four focus groups suggested that to help children with the school transition, it would be helpful to know the curriculum of the schools so providers can work around those expectations. “Maybe having a listing of the things that would be taught for – in kindergarten/first grade so we'll know we're covering all the bases.” Others were interested in knowing the preschool locations in the neighborhood.

Enrollment: Most providers felt that the enrollment process was the role of the parent, not the provider and preferred to not take that role: “That stops the parent from being a parent.” Some providers felt they did not have open enough communication with the parent to discuss preschool and felt the parent would wonder why they were “in their business.” However, 8 participants reported that they were part of school enrollment by taking the child to the doctor, getting the needed information, or just checking in with the parent to ensure they were completing steps on time. Providers also described their role once children were enrolled – they ensure children get to and from school, help with homework, and act as a liaison between the teacher and parent.

Training Delivery

When providers were asked what would be the best way to take a training, in-person training was the most frequent response. While some like the idea of online training because they could work at their own pace, others felt that they needed the training to be hands on. They suggested having handouts during the class, so they can later refer back to the material. All focus groups agreed with the idea of cohort trainings with peers. However, providers had mixed feelings about home visiting. Some saw this as an opportunity to get one-on-one help while others felt that they wouldn’t want anyone in their home or that home visiting wouldn’t work during child care hours: “Well, and I think last time, they came out during the day, so it’s an option of, I'm trying to learn and I have kids, it’s not gonna work.”

For in-person trainings, providers recommended keeping the class small and about 2 hours in length. Their preferred frequency of the training varied from once a week to 4 times a year. When providers were asked about the best day and time for the training, most responses were divided between weekends in the morning, or weekdays in the evening. One focus group said that in middle of the day on a weekday was fine if child care was available.

Providers from a rural community discussed the difficulty of attending in-person trainings because of the distance they had to travel to get to trainings. Providers do not always have transportation or the child care they would need in order to attend. Trainings were not held in their community because local trainings do not draw enough providers and the state requires a ten-person minimum. It was suggested that the state reduce the minimum registration requirement.

Motivation for training: FFN providers reported different motivations to attend training. Learning new ideas or topics was the most common motivation. That was followed by monetary reward, and then food.

Evaluation of FFN Focus Groups

To evaluate the focus groups, we reviewed the focus group transcripts and pre and post surveys and interviewed the community partners that hosted the focus group. Representatives of five out of 6 partner sites responded to our phone interview request. We should note at the outset, however, that this evaluation has an important limitation. It is entirely "internal." Illinois Action for Children research staff helped design the focus groups and their evaluation; facilitated some of the focus groups and analyzed all results; and evaluated the process that it helped design and implement. There is thus room for bias in the following evaluation.

What were the goals of the focus groups, and were the goals achieved?

The focus groups were designed to collect providers' views of what they need in order to provide better care for young children and their role in supporting children's transitions to school.

As indicated in the Findings section above, the focus groups elicited a range of views concerning the reasons FFN providers provided care, the supports they feel they need, their interests in training and professional development, and their role in transitions to school.

What was the recruitment plan for FFN participants to the focus groups?

Illinois Action for Children provided its community partners in Cook County with a list of FFN providers serving the priority populations in their area. Below is the list of those children that meet the criteria:

- Children of teen parents
- Children experiencing homelessness
- Children in families in poverty or deep poverty
- Children/families with Department of Children and Family Services involvement
- Children with disabilities
- Children of migrant or seasonal workers
- Children in families with low caregiver education attainment
- Children in families that face barriers based on culture, language, and religion
- Children of a parent or legal guardian with a disability
- Children/families with refugee or asylum status
- Children in families who face barriers due to immigration status

The CCR&Rs outside of Cook County used their own referral lists to contact providers serving priority populations. Partners contacted providers through calls, mail, emails, and flyers.

What populations of FFN providers were targeted participants in focus groups, and what populations actually participated in the focus groups? Which populations were not recruited successfully?

The partners focused on recruiting FFN providers serving priority populations. According to one site partner, homeless population was one population that they were not able to recruit. One community partner was asked to recruit FFN providers who speak Spanish as their first language. Another partner reported that they also recruited FFN providers who speak English as a second language since they have a high immigrant population. According to the pre survey only 10 participants fell under the priority population. The survey was a self-report so there is the possibility of underreporting results.

Were there lessons learned about better recruitment? Should a better recruitment model be used?

Our partners reported that because FFN providers are themselves a hard-to-reach population, more time to recruit would have made the focus group recruitment more successful. One Cook County community partner reported that they struggled when calling providers as many didn't recognize the name of the community partner site. Instead, providers were more familiar with Illinois Action for Children. The site was not getting responses from the priority population list so they decided to use their own list of providers with whom they have a relationship. That particular site suggested using flyers for recruiting instead of calling.

Did focus group participants feel their views were communicated?

On the post-focus group survey, providers were asked to what extent they agreed with each of the following statements: I felt comfortable expressing my opinion today, I felt my views were understood by the facilitators, and I was able to say anything I wanted to say. Ninety-six percent of participants agreed or strongly agreed with each of the statements, indicating that the facilitators created an environment of relative trust where providers could openly express their views. Participants were also asked three open-ended questions. One asked those who didn't feel comfortable expressing their opinions to explain their reasons. No one expressed any concerns. The second question asked participants to write down anything they didn't get a chance to say during the focus groups. Only two participants had topics they felt they didn't have a chance to express: helping providers to grow and assisting providers in getting health benefits and understanding the tax system with the CCAP checks. Lastly, providers were asked if they had any other comments about their experience with the focus group. All comments reflected positive experiences. "The facilitator was very good and patient. She listened to everyone." No one wrote a negative comment or any suggestions.

What did not go well in the focus groups?

Aside from difficulties with recruiting as described above, one site reported a logistical issue related to miscommunication about the food and snacks that were provided in the focus group. Lastly, three sites said they wished the attendance of participants was higher as we expected to have 10-12 participants in each focus group.

Were the overall focus group questions answered? Are there additional questions that would have been helpful to ask but were not asked?

For the purpose of this project the appropriate questions were asked. The project manager who attended 5 out of 6 focus groups reported that some participants had difficulty in answering questions about what they would like to learn. All six focus groups finished before the predicted time so providers had extra time to make additional comments that were not discussed during the questions. None had any new relevant information regarding resources and trainings.

Were focus groups the appropriate instrument to get the information being sought for designing trainings and supports?

While focus groups allow for follow-up questions to add depth to the data collected, they sacrifice numbers for that depth. We can never be certain that answers are representative of the views of the entire population we seek to understand. Responses in these focus groups were frank and spontaneous, and for that reason we feel they are valuable resources for the team designing pilot trainings.

Were any differences observed that might be related to differences of language, culture or region of the FFN participants?

The project manager reported a major difference in the focus group that took place in Cairo, IL. Community resources in that area seem to be very limited. Providers emphasized their challenges throughout the focus group so much that the project manager eliminated the later questions about the community resources.

Did unexpected but relevant new information come up in the focus groups?

While we expected to find a substantial minority of FFN providers interested in pursuing a home child care license, and a majority uninterested in that career path, we were surprised to find the strong cluster of interest in licensing in one focus group – the Spanish-language focus group – and very little expressed interest in the other groups.

The staff person at one site reported being surprised when hearing about the lack of provider awareness of available resources.

Implications

Designing a statewide program of training and other supports that meets the needs of all FFN providers can be a complex task. Time, language and location are three factors trainers need to consider when developing training for FFN providers. As mentioned by our partners, FFN providers can be a population that is hard to reach and in some cases this can be due to the nontraditional hours they work. Thus, trainings must have multiple dates and times to fit the diverse schedules of FFN providers. Providing child care during the training might be a good solution if trainings are hosted during providers' working hours. Another option is for the trainings to take the form of playgroups.

In Cook County we conducted one focus group in Spanish because Spanish speaking providers compose the second largest group of FFN providers. However, our partners in Moline County reported that their FFN population is mostly composed of Spanish and French speaking providers. Providers who speak French as their first language do not have any type of trainings and resources available in their native language. The partner suggested keeping that population in mind when developing training supports, and of course this may apply to several language groups.

Location was a concern that came up in focus groups outside Chicago. In less densely populated regions, there might be fewer licensed programs in operation, and a large portion of child care might be by FFN providers. In such regions access to transportation or traveling a long distance to attend a training can be challenges for FFN providers, and the focus group confirmed these challenges. When conducting a training, access must be analyzed and ensured. Home visiting training can be a good solution to overcome those barriers for providers (though not for staff). However, providers have mixed feelings about having a stranger in their home. In some cases, then, staff relationships with providers would need to be nurtured to win the providers' trust.

Some providers expressed an interest in learning with and from other FFN providers. Many trainings outside the home could take advantage of this style of interactive adult education.

Providers expressed interest in a number of resources. Materials can be useful as incentives and as educational aids. Providers say they want written materials that they can refer to, particularly as take-home supplements to trainings. They also want educational materials for the children, such as books and games. Providers are very interested in new activities they can engage in with the children. This suggests that programs could make good use of teaching models such as play and learn, both as an incentive for engagement and as a learning device.

It appears that teaching providers to support school readiness and school transitions should not be designed as standalone trainings, but should be built into more interesting trainings or activities that engage providers regarding young children in whatever form they take – for example, playgroups, play and learn sessions, understanding children's behaviors and childhood trauma, child development milestones or stages, and more formal child development. Supplemental reference materials could focus on school readiness or transitions. For example, flyers or fact sheets could discuss what children will learn in preschool and K; what they need to know or how they need to behave when they go to preschool or K; how to enroll locally; what documents the child will need. Other materials, such as how to apply for child care food assistance, might also be

welcome supplements to any trainings or learning activities. And, of course, it would be desirable to have these materials in a number of languages.

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Family, Friend and Neighbor Child Care Providers
Design Training & Supports Evaluation Report

November 14, 2019

Introduction

A design evaluation was conducted by the Research Department at Illinois Action For Children to develop trainings and supports to assist family, friend and neighbor (FFN) child care providers. The design of the model was based on the findings from the six focus groups that were conducted in 4 different counties across Illinois.

Process

The research team presented a summary of the focus groups findings to the department of Provider Resources at Illinois Action For Children. The Project Manager presented the findings to the community partners and the CCR&Rs that are part of the pilot study. A matrix table was created to visualize the trainings that IAFC anticipated based on their previous work with FFN providers, the findings from the focus and the trainings that IAFC currently offers. The community partners and CCR&Rs were asked to review the document for any feedback or comments.

Design

The design team decided to create a training curriculum of 8 hours with 2 hours in each in-person meeting. The first session will start with a training on child development. This training is divided into 5 sections; what is child devolvement, five areas of development, putting child development into practice, understanding developmental delays and best practices to help with the development of children. The second session covers social emotional learning (SEL) and trauma. The social emotional learning aspect will cover the importance of SEL, methods to foster positive SEL, SEL skills needed for school and best practices in teaching SEL. The trauma training will review the importance of understanding trauma in children, types of trauma, how children might behave after a traumatic event and best practices in helping a child and /or family through trauma. The third training session will teach providers ways to use technology with children in a safe manner. The second half of the session focuses on building relationships with parents, challenges of connecting with parents and ways to deal with those challenges. Lastly, during the fourth session providers will learn about the importance of literacy in young children and ways to encourage literacy. The training cohort will end with providers learning about what children will need to know so they can be ready for Pre-K and Kindergarten.

	Training Topic
Week 1	Child Development (2 hours)
Week 2	Social Emotional Learning (SEL) (1 hour) Trauma (1 hour)
Week 3	Children and technology (1 hour) Relationship building with parents (1 hour)
Week 4	Literacy activities (1 hour) School readiness (1 hour)

Evaluation

What were the goals of the design phase, and how were the goals achieved?

The goals of the design phase were to develop trainings and quality supports that directly respond to the needs and interest of Family, Friend and Neighbor (FFN) child care providers. Those needs and interest were discussed during the focus groups. The goals were achieved by incorporating the focus group findings into training and quality supports.

How were the specific findings of the focus groups incorporated into the design of trainings and supports? What were the challenges of doing this?

The design team prioritized the training topics based on the list that matched the topics that IAFC anticipated and the topics that were actually raised during the focus groups. The team used the summary report of the focus groups as guidance. One major challenge that the design phase faced was incorporating training topics that met the needs of all FFN providers. One site (site X) felt that the proposed training topics did not meet the needs of their community as they thought the needs of the community were more basic than the proposed trainings. Therefore, site X designed and implemented their own sessions based on the discussion and findings of that specific focus group.

Were there significant findings of the focus groups or design elements that were omitted from the design for reasons of cost or the timeframe of the pilot?

The design team reported that no significant findings of the focus groups or design elements that were omitted from the design for reasons of cost or the timeframe of the pilot.

Was there important missing information that the designers felt would have helped them in the design process?

More precise information on the preferred dates and times of the training sessions would have been helpful during the design process. However, the designer felt that getting that information during the focus groups would have been difficult due to the non-traditional schedule of FFN providers.

Did the designers feel they had enough time and information about the project to design appropriate trainings and supports?

Knowing more in advance about the type of work and training each community partner and CC&R already do with FFN providers would have been helpful when designing the trainings. Lacking that information in advance, the designers felt it took longer for them to finalize the training topics.

What did the designers feel were their major challenges? How did they address them? What would they do differently in the next iteration?

Narrowing down the training topics to the 8-hour trainings was the major challenge for the designers. The team felt that they had many important topics to cover but realized that not all topics could be covered in an 8-hour training curriculum. The team decided to prioritized the topics based on was anticipated from their experience with FFN providers and what was said during the focus group. Finding the right time to implement the training was another challenge. The designers overcame this challenging by having close communication and meetings with the rest of the team. When the designer was asked what would they do differently, they responded by saying getting more input from the community partners and CC&Rs.

How did the designers consider replicability and scalability as informing their designs?

According the designer, the model can be implemented in different levels as it is basic but still gets into very specific information. The trainings will be put together in a booklet format to allow trainers to review it. Also, the trainers have the option to record the trainings so the training can be shared with others.

Limitations

The 8-hour model aims to train FFN providers based on the findings from the 6 focus groups that were conducted from July-August 2019. The model incorporates most of the main findings from the focus group. However, working with children with special needs, nutrition, and technology literacy for providers are some of topics that FFN providers requested but will not be part of the training curriculum. To provide quality supports, participants will get home visits from the License Exempt Monitoring (LEM) team. The model does not explain in what frequency the home visits will occur or what kind of resources participants will receive during those visits.

Site X will not be following the training model. The site decided to focus on more basic needs, and they had their first session on access to healthy food. The next two possible sessions will be on taxes and access to learning toys.

Recommendation

The six focus groups that were conducted across Illinois showed that FFN providers were interested in various training topics but they were also lacking many resources. Site X showed that some locations have an extreme need of resources and that they were not interested in any formal training model. Perhaps all participants should have given the option to choose from a more formal training model, social capital model or a combination of both. The current model aims to provide professional development through training and support through LEM home visits. The 8-hour professional development will cover child development, SEL, trauma, children & technology, relationship building with parents, literacy and school readiness. All of these topics were mentioned during the focus group. However, the support aspect of the model is not clear. During the focus groups providers said they wanted access to learning materials, learn about outdoor activities/events, help with the cost of food for the children, a lending library where providers could check out free materials among other resources. Perhaps the LEMs can assist in those areas and help providers get connected to community resources. However, the LEMs might need to come up with an alternative solution if providers live in an area with extreme lack of resources.

The project described was supported by the Preschool Development Grant Birth through Five Initiative (PDG B-5), Grant Number 90TP0001-01-00, from the Office of Child Care, Administration for Children and Families, U.S. Department of Health and Human Services.

Evaluation Report-FFN Pilot

By the Illinois Action for Children Research Department, January 30, 2020

The goal of the FFN pilot was to develop a program of trainings and supports responsive to the needs of license-exempt family, friend and neighbor (FFN) home-based child care providers. As we reported and evaluated in the fall of 2019, exploratory focus group were held with FFN providers in six partner sites across the state, and the findings were delivered to the Illinois Action for Children training design team. The partners conducted the resulting pilot program of trainings and supportive home visits with FFN providers in the fall and early winter of 2019 – 2020. This report describes and evaluates those trainings and supportive home visits.

The evaluation of the trainings and home visits had several components using different methods of data collection with different groups of participants. We conducted telephone interviews with a 25 percent sample of the FFN providers who participated in the training. We interviewed the trainers who conducted the trainings as well as the training coordinators at the partner sites who recruited experienced trainers, scheduled the trainings, and recruited providers.

In addition, we surveyed FFN providers who received a supportive home visit. Unfortunately, the home visits outside of Cook County were not completed in time to survey those participating providers and deliver the evaluation on time; therefore only Cook County providers are represented in this part of the evaluation. Lastly, we incorporated findings from a focus group that the manager of License Exempt Monitoring at Illinois Action for Children held with the License-Exempt Monitors who conducted the supportive home visits.

Training Participants and Sites

A total of 62 providers participated in the 2019 FFN training and support program. The three Cook County partner sites that hosted the trainings were Good Shepherd Center, Carole Robertson Center for Learning and Centers for New Horizons. Details appear in Table 1. The training in Carole Robertson Center for Learning was conducted in Spanish. Outside Cook County, trainings took place in SAL Family and Community Services located in Rock Island County and in SAL Child Care Connection located in Peoria County, each of which is the state's Child Care Resource and Referral Agency for their community.[1]

[1] The Child Care Resource and Referral Agency for Alexander County was initially part of the evaluation. However, due to the urgent need of providers for resources, the site decided to start their own training and support program before the pilot study program was designed and implemented. Thus, it was excluded from the research evaluation.

Table 1. FFN Provider Participation by Site Partner

Site	Number of Participants
SAL Family and Community Services (Moline)	22
SAL Child Care Connection (Peoria)	15
Carole Robertson Center for Learning (Chicago)	15
Centers for New Horizons (Chicago)	7
Good Shepherd Center (Hazel Crest)	3
Total	62

Demographics of FFN Participants

Of the 62 participants, 60 completed the pre survey and reported their demographic characteristics. (See Table 2.) These providers were relatively older than the typical FFN provider. Eighty-six percent were over 40 years old, compared to 62 percent among all FFN providers in the Illinois Child Care Assistance Program (CCAP) in Cook County.

Just as younger providers were underrepresented in the trainings, so too were short-term providers. Only 18 percent had been caring for a child with CCAP one year or less, while 65 percent of all FFN providers care for children only 1 year or less (at least in Cook County CCAP). Although these providers are not fully representative of FFN providers in CCAP, they do represent an important segment of FFN providers who are relevant to training: those who have enough longevity in the program to participate in trainings over a longer term and might be interested in gaining useful knowledge of child development and other topics from a training.

Finally, a portion of the FFN provider participants care for children who are part of what the state considers priority populations: children with special needs, children of teen parents and children of immigrant or refugee parents. FFN provider participants also care for children during nonstandard hours, though at a lower rate (43 percent) than the larger population of FFN providers (72 percent in Cook County).

Table 2. Demographic Characteristics of FFN Training Participants

	Cook County	Other Counties	Total
TOTAL PROVIDERS	25	37	62
Age of providers			
Age 39 or under	4	4	8
Age 40 or above	17	31	48
Ethnicity			
Latinx/Hispanic	14	0	14
Race			
American Indian or Alaska Native	2	0	2

Asian or Asian American	2	0	2
Black or Black American	8	20	28
White	4	16	20
Other	8	0	8
Amount of time caring for children under CCAP			
1 year or less	6	5	11
2-4 years	10	13	23
5-9 years	6	9	15
10 or more years	2	9	11
Children in care			
1 child	3	8	11
2 children	9	12	21
3 children	9	10	19
4 children	1	3	4
5 or more	2	2	4
Ages of Children in Care			
Care for children under 5	24	31	55
Serving priority populations			
Children with Special Needs	3	6	9
Children of teen parents	6	0	6
Children of immigrant parents	4	0	4
Children who have a refugee or asylum status	2	0	2
Hours of care			
Children in care during nontraditional hours	11	15	26

**Some providers did not answer some demographic questions.*

Trainings and Supports

Process

The trainings for FFN providers covered several topics over a total of 8 hours. They were

- Child Development (2 hours)
- Social Emotional Learning (1 hour)
- Trauma (1 hour)
- Children and Technology (1 hour)
- Relationship Building w/ Parents (1 hour)
- Literacy (1 hour)
- School Readiness (1 hour)

The Carole Robertson Center for Learning and Good Shepherd Center completed the 8-hour training in a series of three days while Centers for New Horizons, SAL Family and Community Services and SAL Child Care Connection held the entire training in one day. All trainings were Gateways approved and facilitated by experienced trainers. At the end of training, providers received a gift card for their participation. About 2-4 weeks after the training, a sample of participants (15) were called for a follow-up telephone interview. Participants were selected from a list of providers that were interested in participating in the phone interview. In the interview we were interested in learning about participants' overall experience with the training and changes they were making in their child care practice. Participants that completed the follow-up interview received a play materials kit valued at $30 dollars.

Also, as part of the pilot study, providers that signed up for the 8-hour training were offered one home visit. The supportive home visits were conducted by License Exempt Monitors (LEM) employed by the Child Care Resource and Referral Agency in each community. During the Cook County home visit providers were given a folder which included information on Early Learning Department, Outreach and Referrals Department, Mental Health Consultants Department, and Chicago Early Learning (see Appendix A). They also received a pamphlet with the essential core and academic competencies that children need to achieve. Lastly, Cook County LEMs identified the nearest food bank and library. To evaluate the home visits, an online survey was distributed to the providers who received a visit. Participants who completed the home visit and the online survey were mailed a kit valued at $200 dollars.

Training Evaluation

Here we list the training evaluation questions and summarize the fifteen FFN providers' responses.

What motivated you to attend the trainings?

Thirteen providers responded that their main motivation was to learn more about how to care for children. The other two providers reported that they only attended the training because they were told the training was required. Two providers mentioned that they felt it was essential for them to learn more about child care as they were trying to get their license.

Were the training topics interesting and useful to you as a child care provider?

Fourteen of the providers felt that the topics were interesting and useful. Only one provider – one who cares for children with special needs – felt the topics were not useful. She felt none of the training topics were relevant to her since the training did not talk about working with children with special needs

Were you able to understand the lessons of the training and follow along with the facilitator?

All providers felt that they were able to understand the lesson of the training and follow along with the facilitator.

What lessons or ideas from the training do you feel you will be able to apply?

Ten providers (67 percent of those interviewed) felt that they heard new ideas. They cited ideas about how to keep children engaged with activities, calm agitated children down, use music, incorporate basic math on a daily basis, and how to better communicate with parents. Providers also mentioned that the training made them more aware of the manner in which they talked to children and how children's behavior – particularly challenging behavior -- is shaped by their immediate environment. At the time of the phone interview, four of the 15 providers could not remember any lessons or ideas they learned. And, as mentioned, one provider felt there were no ideas or lessons that she could apply to her care practice.

Have you implemented a new method/concept as a result of the trainings? If so, which one? What barriers did you face when trying to implement a new method/concept?

Given that the interviews occurred only 2-4 weeks after the training (due to delays in scheduling the trainings), less time was allotted than we had originally designed for the FFN providers to incorporate new ideas in their practice. Nevertheless, ten providers (67 percent of those interviewed) reported that they have already tried to implement a new method that they learned from the training. The newly implemented methods included the following: incorporating more reading activities with children, talking to children in a more precise manner, dealing with a child crying, creating more indoor games, and working with parents to address cases of trauma. From the 10 providers that reported changes in their practice, none of them reported facing any barriers implementing the change. Five participants said they have not yet implemented a new method from the training.

Was there a topic that the training did not cover but you feel would have been helpful to cover? If so, which topic?

Four providers felt it would have been helpful to cover other topics such as working with children with special needs (specifically autistic children), more in-depth coverage of trauma, dealing with children who only engaged in activities with electronics, and ways to better support school-age children who have issues at school. The rest of the providers (11) did not recommend an additional topic.

How could the training be improved?

One provider suggested that the training could be improved by offering alternative training times. The provider had to pay someone to substitute for her and provide care while she was at the training. Another provider said that during the training there was a child present, and at times this created interruptions. That provider suggested making sure there is a strong policy of no children allowed during adult trainings.

In general, how could we better support you as a child care provider?

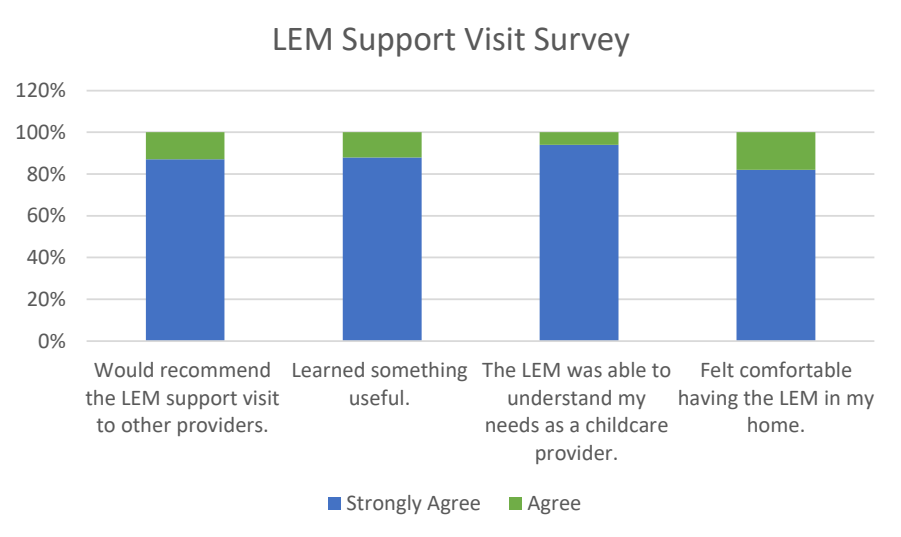
Overall, providers asked for more trainings and resources to be available to them. They also asked for the CCAP payment to be higher and for CCAP payment process to be more efficient. One provider said she needed help obtaining her child care license.

Home Visit Evaluation

At the time of the evaluation, the license-exempt monitors (LEMs) in Cook County were the only LEMs who had completed supportive home visits with the providers who had attended the training. Therefore, we were not able to collect data on the support visits in the other counties.

The Cook County LEMs conducted 26 support visits. One provider in the training program declined to have a support visit. Two providers who were scheduled to attend the training program but did not show up still received a home visit from a LEM. Seventeen participants completed the online survey after their support visit.

Cook County providers responded very positively to the LEM support visit. They unanimously expressed some level of agreement on recommending the visit to other providers, learning something useful during the visit, feeling that the LEM understood their needs and feeling comfortable with hosting the LEM in their home.



The online survey included three open-ended questions:

How could the LEM support visit have been more helpful to you?

All providers expressed great satisfaction with the support visit and none offered suggestions on ways to make the visit more helpful. It is probable that a key to the successful home visits was the ability of the LEMs to forge personal relationships: "She was able to explain everything clearly. She was helpful and very kind."

If the LEM support visits were available to other License Exempt providers, what would be the best way to invite those providers to participate?

When we asked providers how we can reach out to other providers to offer them a support visit, responses were split between texting and mailing providers. Only one provider suggested using social media as a way to reach providers. (Reminder: Most of the participants were over 40.)

Would the LEM support visit have been as useful if it took place somewhere else, such as a training room, a library or an office?

Six providers felt that having the LEM support visit at home was a better method since it was more convenient for them. However, seven recommended having the support visit in more public places like an office, library, training room or in a group setting. Only two providers felt that the setting did not matter.

This small sample suggests that training programs for FFN providers should have a mixed training-delivery system with both home visits and gatherings in another friendly location.

Delivery Staff

The Illinois Action for Children Research and Evaluation Analyst attempted to conduct telephone interviews with at least one trainer or training coordinator in each site. Two trainers and 5 training coordinators responded to the invitation for a telephone interview. Due to time limitations, the Cook County LEMs were interviewed as a group by the LEM program manager.

- **Trainer**

  What was your method of delivering the training?

  Trainers conducted trainings in person. They used Power Point to present the material and had some handouts for providers. One of the sites that conducted the entire training in one day said that they took multiple breaks in between which allowed for providers to ask more one-on-one questions.

  How do you feel about the value of this training for FFN providers?

  One trainer reported that although providers had some difficulty understanding the content of the training, they all learned a lot of new material. The other trainer felt that

the training added a networking component which providers valued. That trainer added that providers were also now eager to attend more trainings.

What do you feel was most and least valuable about the trainings?
The most valuable aspects of the training, according to the trainers, were getting new knowledge and having all providers come together and learn from each other. One trainer reported that the least valuable aspect was having pre-set topics in the 8-hour training schedule. This trainer wished they had more flexibility to customize the training according to the needs of their community. Having LEM's input on the selection of training topics would have been a more effective approach for that trainer, since LEMs are the ones who interact on a daily basis with FFN providers. Also, child development is a topic that is required by the new policy of the State of Illinois, so having it again as part of the pilot study felt redundant according to a trainer.

What challenges did you encounter in delivering the training?
Having an audience with different levels of education and having just one day to work with FFN providers were some of the challenges trainers encountered. The limited time kept providers from sharing more personal experiences.

What changes would you recommend?
The trainers suggested going more in depth with some of the topics. This will allow trainers to build a relationship with providers. Trainers also recommended conducting the training in a series over multiple days and not one long day.

Did you learn anything new about training FFN providers?

One trainer was surprised to see how some providers face many challenges on a daily basis but they still choose to provide care because they love the children in their care. Another trainer reported that she learned that trauma can be a very sensitive subject for FFN providers, as providers may be also experiencing the same trauma that the child is experiencing.

Did you feel you were sufficiently trained to deliver the training to FFN providers?
Both trainers felt they were prepared to train FFN providers. One trainer reported participating in a few LEM home visits to get an idea of the needs of FFN providers.

- **Training Coordinator**

What populations of FFN providers were the target participants for training?

To target participants for the training, one site used the CCAP payment file and sent flyers to providers who have been in the program in the last 3 months. Two sites recruited participants based on those who attended the focus group. When sites didn't get responses from the providers, they recruited providers with whom they had an existing relationship.

Did you have any challenges recruiting providers?
Coordinators reported some miscommunication with the project staff which made it difficult to recruit providers on time. Also, for sites with multiple training days, they found it difficult to coordinate dates and times that worked with all providers. However, those sites with one-day training felt it was hard to get providers' commitment to one full day. While one site over-recruited knowing that not everyone would show up, another site reported having a waiting list of participants interested in the training.

How was the trainer recruited?
Some trainers were recruited through Illinois Action for Children's list of qualified trainers. Some sites used in-house trainers or recruited trainers with whom they had previously worked.

Did you have any issues recruiting a trainer?
Other than the lack of time, training coordinators did not report any problem in recruiting trainers.

Where were the trainings delivered?
Trainings were delivered in an office or training room of each site.

If you were to coordinate trainings for FFN providers, would you do anything different?
To coordinate future trainings with FFN providers, coordinators suggested better planning and having more time for planning. One coordinator recommended creating training groups based on providers' level of education or dividing providers caring for relatives from providers caring for non-relative children. One coordinator said it would have been better if the training were scheduled over multiple days instead of one. However, another training coordinator felt that an eight-hour training day is the appropriate approach for FFN providers.

- **License-Exempt Monitors**

- When LEMs were gathered to talk about their overall experience with the support visits, they reported gaining a deeper connection with providers. Also, working in this project created a stronger working relationship between LEMs and community partners. LEMs noted that during their support visit some providers showed interest in becoming licensed home providers.
- However, LEMs also wished they had more communication with the project staff during the process. Other challenges include having incorrect contact information for an FFN provider, being unable to contact the provider, and distractions during visits (e.g. from active children being present).

Conclusion / Discussion

Older and longer-term FFN providers were disproportionately represented in the trainings and thus in our subsequent data collection. This is not inappropriate since it is important in Illinois to engage this group of FFN providers in improving child care and child outcomes. We cannot assume, however, that these providers' views represent those of all FFN providers in Illinois. We need to understand younger providers and shorter-term providers better. That would require further research, ideally with additional pilots and evaluation that target those groups.

The FFN pilot design had a very tight schedule that in the end could not be strictly followed. The trainings began somewhat late in the different sites because of communication and scheduling challenges that are common to multi-site projects, and this delayed the next stage in the pilot, LEM visits to FFN homes. Delays affected the evaluation in two ways. We had to conduct the follow-up telephone interviews closer to the time of the trainings than we felt was ideal for learning about providers' changing their practices as a result of the trainings. We also were unable to collect survey data on home visits in the Peoria County and Rock Island County sites because those visits were scheduled later.

Overall, the FFN providers expressed positive responses to their training in their interviews, and 67 percent implemented new ideas. It is notable that in follow-up interviews, this group was very specific and positive about what they had learned and were changing in their practice: "I learned how to make reading more interesting that I should read one page at a time and review what they learned or ask them questions about it." This is the strongest evidence we have of the positive impact that trainings had.

The majority of the FFN interviewees were not prepared to recommend additional topics that they would like to cover in trainings. Smaller numbers recommended these topics: supporting school-age children to address challenges at school, disengaging children from technology, and covering trauma and special needs (specifically autism) more deeply. Although it is a bit broader than a training topic, help in getting a child care home license was also mentioned.

Some providers expressed an initial reluctance to let a stranger visit their home, and even after a positive visit, some still felt that way. They recommend using friendly public spaces for this.

Finally, the need for flexibility was a persistent theme of the interviews and survey. Since providers and the families they serve face many challenges, and since the best way to engage providers is with topics that directly matter to them, it makes sense to give the trainer flexibility to adjust training topics to the specific needs of the providers in attendance, rather than follow a rigid curriculum. It would, moreover, serve the diversity of providers to give flexibility to training programs to offer trainings of different lengths – all day or a series of shorter programs, and at several times of day or week, and to offer both home visits and gatherings in a friendly public place. Furthermore, a provider and an LEM reminded us that children can be a distraction during trainings and home visits; and since children probably cannot be fully kept from such settings, trainers and LEMs need to be trained well-enough and flexible enough to address those distractions.

When scaling the pilot program to a state wide initiative, we must consider training with multiple levels, have different formats of the training, more than one language, and determine the needs of providers by community

Multiple levels of training helps providers to select which level they would like to take based on their previous knowledge of the topic and interest. Given the nontraditional schedules that FFN providers work, the lack of transportation in rural areas and the diverse population of FFN providers, to be more inclusive trainings need to be online and in person training and have the training in at least one language other than English. Lastly, each community has its own weaknesses and strengths thus, quality supports and trainings should be based on the needs of each community.

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Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Office of Child Care, the Administration for Children and Families, or the U.S. Department of Health and Human Services.

Appendix A

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Social and Emotional Development

3 Months

- Imitates and responds to a smile
- Enjoys playing with others and may cry when playing stops
- Becomes more expressive and communicates more with face and body
- Imitates some movements and facial expressions

7 Months

- Enjoys social play
- Interested in mirror images
- Responds to other people's expressions of emotion and appears joyful often
- Babbles and laughs
- Uses voice to express pleasure and displeasure

12 Months

- Recognizes parents and caregivers, prefers them over others
- Cries when parents leave
- Shy or anxious with strangers, fearful in some situations
- Enjoys imitating people in play
- Shows specific preferences for certain toys
- Tests parents/caregivers responses to his actions and behavior
- Repeats sounds or gestures for attention

24 Months

- Imitates behavior of others
- More aware of herself as separate from others and more self focused
- More excited about company of other children
- Demonstrates increasing independence
- Begins to show defiant behavior
- Separation anxiety increases toward midyear then fades
- Accepts limits
- Communicates needs using simple language

3 Years

- Imitates adults and friends
- Shows emotion spontaneously to playmates
- Can wait their turn when playing
- Understands "mine" and "his/hers/yours"
- Expresses a variety of feelings
- Dislikes changes to their routine

4 Years

- Has great imagination, imaginary friendships, "monsters", fantasy vs. reality
- Shares and plays with other children
- Uses words to express emotions
- Tries to resolve or negotiate conflicts
- Is more independent but still needs adults

5 Years

- Friendships are important – fitting in and pleasing others
- At times plays well with peers, at times very demanding
- Is very strict about the rules
- Is more independent
- Issues of gender and sexuality
- Understands fantasy vs. reality

Factors that affect social and emotional development

Physical Factors:

- Illness and Accidents
- Nutrition
- Quantity and quality of sleep

Emotional Factors:

- Loss of caregiver (divorce, death, move)
- Abuse, neglect, or trauma
- Not enough quality time with a caring adult

Social and Cultural Factors:

- Parenting styles
- Family's beliefs about emotions
- Community environment
- Violence or substance abuse at home

All children need:

- **Love, Love, Love!**
- Support of family and child care providers
- A safe environment that encourages learning
- Activities and opportunities to learn specific skills like: sharing, talking about emotions, and taking turns.

Some children need:

- Observation by mental health consultant (see bottom right information)
- Examination or evaluation
- A behavior plan
- Specialized services like speech therapy, social work, or special education services

Document created by:
Elysia M. Aufmuth, LCSW

Warning Signs: 0 - 3 years

- Feeding or sleeping difficulties
- Frequently bites or hits others with no provocation
- Anxious and clingy attachment to caregiver
- No stranger anxiety; indiscriminate attachment
- Sad facial expression; avoids eye contact
- Uncomfortable when held
- Too easily upset and difficult to soothe; excessive crying

Warning Signs: 3 – 5 years

- Engages in compulsive activities (e.g. headbanging)
- Throws wild, despairing tantrums
- Withdrawn; shows little interest in social interaction
- Displays repeated aggressive or impulsive behavior
- Difficulty playing with others
- Little or no communication; lack of language
- Loss of earlier developmental achievements

Information:

- **Center on the Social and Emotional Foundations for Early Learning**. http://www.vanderbilt.edu/csefel/
- **Early Childhood Direction Center**. http://ecdc.syr.edu/checklist_download.html
- **Silva-Zletz, Olga and Margarita Paredes**. The Social and Emotional Development of Your Baby.
- **Kabb, Laurie**.*Identifying Mental Health Issues in Young Children: When to Call in the Troops*. Presented 9/28/05

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